McCARTER ENGLISH
ATTORNEYS AT LAW

May 7, 2007

VIA ELECTRONIC FILING & HAND DELIVERY

The Honorable Mary Pat Thynge
United States District Court for the District of Delaware
844 North King Street
4th Floor, Room 4209
Wilmington, DE 19801

Christopher A. Selzer
Associate, Business Litigation

Re: Daniel Miller v. ARAMARK Healthcare Support Services Inc. et al.
C.A. No. 06-534 (MPT)

Dear Judge Thynge:

McCarter & English, LLP
Citizens Bank Building
919 N. Market Street -18th Floor
Wilmington, DE 19801
T. 302.984.6300
F. 302.984.6399
www.mccarter.com

I write to provide Your Honor with additional information regarding the discovery dispute. Specifically, Your Honor has requested additional information regarding Plaintiff's request for all work order requests, including initial inspections, repair orders, preventative maintenance inspections and on-call responses for Plaintiff from February 2, 2005 to April 15, 2005, and Plaintiff's request for documentation of all preventative maintenance inspections performed by John Ritterhoff from March 1, 2005 to April 15, 2005.

I. Plaintiff's Requests Are Irrelevant

Plaintiff's counsel claim that they need to obtain these documents to demonstrate three things: (1) the amount of work requested of Plaintiff, (2) the amount of work that Plaintiff completed and (3) that Plaintiff's was unfairly disciplined for certain performance issues. Plaintiff's counsel, however, has failed to demonstrate how these additional documents would show these things or otherwise support any of Plaintiff's claims in this action.

As an initial matter, Plaintiff's counsel cannot establish that Plaintiff was required to work more than other technicians through these documents alone. Without having copies of the same documents for the other Clinical Engineering Technicians, which Plaintiff's counsel did not request, they will have no basis for comparison. Furthermore, the complexity of the equipment worked on by the technicians varies as much as the equipment itself. Declaration of Jonathan Hill dated May 7, 2007 ("Hill Decl.") ¶4, which has been attached hereto as Exhibit A. Currently, there are over 8,000 pieces of medical equipment at Bayhealth Medical Center ("Bayhealth") representing 583 different classifications of medical equipment. Hill Decl. ¶4. The equipment ranges from simple devices (e.g., a suction regulator or an oxygen flow

meter) to very complex devices (e.g., a defibrillator), which require a higher level of knowledge and more time to install, inspect and repair. Hill Decl. ¶4. With all the variations of medical devices and equipment problems that can be presented, there is no concrete way to determine whether one technician worked harder than another technician. Hill Decl. ¶4.

Additionally, Plaintiff's disciplinary issues did not involve the quantity of work he completed. Rather, Plaintiff received disciplinary write-ups for failing to properly complete his documentation even after receiving specific instructions on how to do it and for violating Bayhealth's safety policies. See Plaintiff's disciplinary documents, which have been attached hereto as Exhibits B to E. Defendants ultimately terminated Plaintiff's employment because of his documentation problems and two major safety violations (i.e., the improper installation of an emergency stop-switch on a treadmill and the failure to tag or remove a defective defibrillator from the hospital floor). See Memorandum dated 4/15/2005 re. "Termination Discussion with Dan Miller," which has been attached hereto as Exhibit F; Deposition of Jonathan Hill, taken on February 14, 2007 ("Hill Dep.") at 104-06, cited deposition pages are attached hereto as Exhibit H.

Finally, looking at Mr. Ritterhoff's preventative maintenance forms will not establish him as a valid comparator. Plaintiff's counsel cannot tell simply from looking at these forms whether he performed his job incorrectly. Rather, Plaintiff's counsel would need supporting testimony from someone who actually observed a problem with Mr. Ritterhoff's preventative maintenance. For example, you cannot tell from the preventative maintenance form submitted by Plaintiff on April 4, 2005 that he violated Bayhealth's safety policies by failing to either remove this defective defibrillator from the hospital floor or tag it as defective. See Preventative Maintenance form dated 4/4/2005, which has been attached hereto as Exhibit G; Hill Decl. ¶5. Rather, it is Mr. Hill's testimony regarding the discipline that Plaintiff received in connection with this preventative maintenance that establishes his violation of safety policies. See Exhibit E; Hill Dep. at 90-98, 139-40. Similarly, Plaintiff's counsel cannot establish that Mr. Ritterhoff performed his job incorrectly simply by looking at his preventative maintenance forms.

Moreover, only looking at Mr. Ritterhoff's preventative maintenance forms provides an incomplete picture of his work performance. Conducting preventative maintenance is just one part of a technician's job. Technicians must also effectively install new devices and repair defective equipment. Hill Decl. ¶3. Therefore, even if Plaintiff's counsel could identify deficiencies in Mr. Ritterhoff's preventative maintenance forms, this will not given them a full picture of Mr. Ritterhoff's performance as a technician. However, other than his date of birth, his job

description, his competency assessment completed in 2004 or 2005, his 2004 performance evaluation and his disciplinary records, Plaintiff's counsel did not request any other documentation or information pertaining to Mr. Ritterhoff. Because Plaintiff was disciplined and ultimately terminated for safety violations and performance deficiencies in areas other than preventative maintenance, Plaintiff's counsel cannot establish Mr. Ritterhoff was similarly situated to Plaintiff based solely on Mr. Ritterhoff's preventative maintenance forms.

II. Plaintiff's Requests Will Pose An Undue Burden on Defendants

In order to identify all the documented work for Plaintiff and Mr. Ritterhoff, Mr. Hill must conduct an extensive search. He must review all of the work orders entered onto the computer to find ones assigned to either Plaintiff or Mr. Ritterhoff because the technicians did not always enter their name as the assigned employee. Hill Decl. ¶6; see e.g., Exhibit G. Defendants' computer system currently counts 2,287 work orders for the time period of February 1, 2005 to April 15, 2005. Hill Decl. ¶6. Mr. Hill must also conduct a computer search to determine whether a status was entered by either Plaintiff or Mr. Ritterhoff even though the work was not necessarily assigned to that technician. Hill Decl. ¶6. Defendants' computer system currently counts 5,253 statuses for the time period of February 1, 2005 to April 15, 2005. Hill Decl. ¶6. Mr. Hill must also review the equipment files for additional documentation that is not present in the work order. Hill Decl. ¶6. He does not currently know how many equipment files he would need to search because that depends on how many different pieces of equipment the 2,287 work orders pertain to. Hill Decl. ¶6. This is clearly a monumental undertaking. Therefore, even assuming that such documents might be relevant, the burden to Defendants far outweighs whatever little relevance such information allegedly possesses.

Additionally, David Walczak, Bayhealth's Chief Information Officer, informed Mr. Hill that Defendants cannot produce all of the work orders, including initial inspections, repair orders, preventative maintenance inspections and on-call responses for the time period of February 1, 2005 to April 15, 2005. Hill Decl. ¶7. These documents are the property of Bayhealth. Hill Decl. ¶7. Instead, if Plaintiff's counsel wants to obtain these documents, they must subpoena Bayhealth and give its lawyers an opportunity to object to the request. Hill Decl. ¶7.

Thank you for your consideration and attention to this matter.

Respectfully,

/s/ Christopher A. Selzer

Christopher A. Selzer (DE Bar ID #4305)

cc: William D. Fletcher, Jr., Esquire (via e-file)
Noel E. Primos, Esquire (via e-file)
Michael P. Kelly, Esquire
William J. Delany, Esquire
Anne E. Martinez, Esquire

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

DANIEL MILLER, Plaintiff, v. ARAMARK HEALTHCARE SUPPORT SERVICES, INC., ARAMARK CLINICAL TECHNOLOGY SERVICES, INC., AND ARAMARK MANAGEMENT SERVICES LIMITED PARTNERSHIP, Defendants.	Civil Action No. 06-534-MPT

Declaration of Jonathan Hill

I, Jonathan Hill, depose and state as follows:

1. I have been employed by ARAMARK Clinical Technology Services, Inc. or a predecessor since approximately January of 1995 and have worked at the Bayhealth Medical Center ("Bayhealth") since 2004 as the Frontline Manager.

2. I submit this Declaration in support of Defendants' letter to the Honorable Mary Pat Thynge in the above-captioned matter. This Declaration also supplements my sworn deposition testimony provided on February 14, 2007.

3. Bayhealth's Clinical Engineering Technicians have several responsibilities, including the installation, preventive maintenance, and repair of Bayhealth's medical equipment.

4. The complexity of the equipment worked on by the technicians varies as much as the equipment itself. Currently, there are over 8,000 pieces of medical equipment at Bayhealth representing 583 different classifications of medical equipment. The equipment ranges from simple devices (e.g., a suction regulator or an oxygen flow meter) to very complex devices (e.g., a defibrillator), which require a higher level of knowledge and more time to install, inspect and

repair. With all the variations of medical devices and equipment problems that can be presented, there is no concrete way to determine whether one technician worked harder than another technician.

5. I recognize Exhibit G (bates-labeled A00042-43) in support of Defendants' May 7, 2007 Letter to The Honorable Mary Pat Thynge as a true and correct copy of the Preventative Maintenance form that Daniel Miller submitted on or about April 4, 2005 regarding the defective defibrillator that he discovered in the Intermediate Care Unit.

6. In order to identify all of the documented work completed by Mr. Miller and Mr. Ritterhoff, I must review all of the work orders entered onto the computer to find ones assigned to either Plaintiff or Mr. Ritterhoff because the technicians did not always enter their name as the assigned employee. Our computer system currently counts 2,287 work orders for the time period of February 1, 2005 to April 15, 2005. I must also conduct a computer search to determine whether a status was entered by either Mr. Miller or Mr. Ritterhoff even though the work was not necessarily assigned to that technician. Our computer system currently counts 5,253 statuses for the time period of February 1, 2005 to April 15, 2005. I must also review the equipment files for additional documentation that is not present in the work order. I do not know how many equipment files I would need to search because that depends on how many different pieces of equipment the work orders pertain to.

7. David Walczak, Bayhealth's Chief Information Officer, informed me that Defendants cannot produce all of the work order requests, including initial inspections, repair orders, preventative maintenance inspections and on-call responses for the time period of February 1, 2005 to April 15, 2005. These documents are the property of Bayhealth.

Accordingly, if Mr. Miller's attorneys want to obtain these documents, they must subpoena Bayhealth and give its lawyers an opportunity to object to the request.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing information is true and correct, based upon my knowledge, information and belief.

DATED: May 7, 2007

JONATHAN HILL

Exhibit B

ARAMARK

Hourly Performance Plan Form

EXHIBIT
Hill 4
Case 2/14/07

☒ Coaching Discussion ☐ Counseling Discussion ☐ Formal Warning

☐ Follow-up Discussion ☐ Suspension Notice (Fact finding Only, Do not complete the 2nd and 3rd boxes)

Name: DAN MILLER Social Security #: 183-42-5008

Position: Clinical Engineer Comp. Name: ARAMARK Cuyahoga #7517

Your Conduct / performance requires improvement for the following reasons: (Describe the performance issue and reasons improvement is required, use additional paper if necessary)

- ASSETS Added To The Computer System need To be Accurate and Follow same FORMAT AS INSTRUCTED DURING Competency Testing.

The expected level of performance / conduct is:

- When ASSETS ARE Changed, updated or Added, There needs To Be ACCURACY and Completeness IN YOUR ENTRIES. Leaving INFORMATION OUT OR IN A Questionable STATUS Delays Record Review & WORKFLOW.

The following solution(s) have been agreed upon to correct the conduct / performance:

- Verify Information IS Accurate & IN Proper Place in Records
- Verify Completeness of Documentation (BOTH Paper & Computer)

Date Solution(s) will be implemented: JAN 3/4/05 Completed: JULY 3/4/05

Potential consequence in continuing current behavior is: FURTHER Disciplinary Action.

A follow-up to discuss your progress will be held on: N/A

Daniel Miller 3/4/05
Employee's Signature Date

Manager's Signature 3/2/05
Date

Human Resources / Other (if applicable) Date

Note: Employee's signature on this form indicates that this situation has been discussed. It doesn't necessarily mean the employee agrees.

No Class Training of T.S.T.S

Miller Co

A00035

ASSET INVENTORY DETAIL

BAY HEALTH

ARAMARK

00016301

ntification

et Number:	469914
al Number:	US00103118
em:	DEFIBRILLATORS
ect:	M4735A
Common Name:	DEFIBRILLATOR/MONITOR
Service:	CEM
Class:	DEFIB./MON., BATT. PWRD.-11-129A
Manufacturer:	AGILENT TECHNOLOGIES (PHILIPS MEDICAL SYSTEMS)

cation

e:	KGH
ding:	Kent General Hospital
t:	3 WEST
m:	

PM

Base Month:	6/2003
Shutdown Months:	000000000000
Priority:	Urgent
Printer:	
Link Group:	
Shop:	CTS BIOMEDICAL

PM Indicators

Indicator - 1	
Indicator - 2	
Indicator - 3	
Frequency:	
Frequency:	
Frequency:	

Miscellaneous

Inventory Date:	12/6/2001
Installation Date:	10/15/2001
Storage Date:	

Warranty

Disposal Date:	2/28/2005
Labor Start:	
Labor End:	10/15/2006
Material Start:	
Material End:	10/15/2006

k Factor

ip Type:	Medical	
ction:	8	Critical - Therapeutic
:	7	Death or Serious Injury
ory:	1	0 - 1
l Risk:	16	
:	Tier 1 (High Risk)	
Schedule:	Regular	

Financial

Purchase Price:	$8,000.00
CMI Allocation Cost:	
Cost Center:	11-6120 - 3W MED/SURG

Personnel

Employee:	
Contact 1:	
Contact 2:	

Note:

Defined

(iSAMM contract) Status: PC (iSAMM contract) Glass: 00 Mfg: AGILENT Model: M47
(iSAMM contract) Hours: 85 iSAMM Service Rep ID: 135

Non-... INITIAL INCOMING INSPECTION & EQUIPMENT EDIT FORM

SECTION I

ACTS # 848021

☐ System ID
Old ID: ________
Hosp. Asset #: 18177

☒ = Addition To Inventory
☐ = Edit/Change To Inventory
☐ = Delete From Inventory

10338 Joh

SERIAL NO.: US00103381

COMMON NAME: Bi-Phasic defibrillator

MANUFACTURER: Philips Medical

MODEL NO.: M4735A

COST CENTER: 11-6120

LOCATION:

ZONE: KGH

BUILDING: Kent General Hospital

FLOOR: 3rd

DEPARTMENT: 3 East Med/Surg.

SCO:

SYSTEM: Defibrillator

CLASS: Defib/Mon. Batt. Pwrd 11-129A

OBJECT: M4735A (Philips Medical)

PURCHASE PRICE: $ Exchanged / Repair

INVENTORY DATE: 02/28/05

INSTALLATION DATE: __/__/__

WARRANTY INFO:

WRTY: LABOR START	WRTY: LABOR END
10/15/01	10/15/06

WRTY: MATERIALS START	WRTY: MATERIALS STOP
10/15/01	10/15/06

OWNERSHIP
☒ HOSPITAL
☐ CONTRACTED
☐ LEASE/LOAN/RENTAL
☐ OTHER

☐ ASSET IS UNDER AN OEM SERVICE CONTRACT

DELETE:
DISPOSAL DATE: __/__/__

CAPITAL PURCHASE ORDER #________

ADDITIONAL NOTES OR COMMENTS: Changed Asset Tag (Bayhealth) from CTS 469914

SUGGESTED TIER LEVEL:
TIER 1___ TIER 2___ TIER 3___

BASE MONTH ________

☐ ANNUAL ☐ MONTHLY ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ OTHER ________

LEASED EQUIPMENT: START DATE: __/__/__

DURATION: ______ ___DAY(S) ___MONTH(S) ___WEEK(S) ___YEAR(S)

Notes OUTPUTS

50 = 50 Joules
100 = 99 Joules
200 = 198 Joules
AED 150 = AED 148

UAL INSP	GROUND RES Ω	NP (OFF) µA	NPNG (OFF) µA	NP (ON) µA	NPNG (ON) µA	MAX LEAD LEAKAGE µA	LEAD ISO. µA
OK	.08	0	164	.1	158		

A00037

SECTION II

1. Does the device appear to be undamaged?
   - ☑ Yes: Proceed to step 2.
   - ☐ No: Do not accept for use and contact seller for corrective action.
2. Is the device electrically operated by 120 VAC?
   - ☑ Yes: Proceed to step 3.
   - ☐ No: Proceed to step 6.
3. Has the device been evaluated by a qualified testing laboratory? Refer to hospital policy and state administrative code or policy, if applicable.
   - ☑ Yes: Proceed to step 4.
   - ☐ No: Do not accept for use and contact seller for corrective action.
4. Visually inspect power cord, plug, and strain relief's. Refer to NFPA 99 chapter 9.
   - ☑ Pass: Proceed to step 5.
   - ☐ Fail: Do not accept for use and contact seller for corrective action.
5. Does the device pass electrical safety inspections? Refer to NFPA 99 Chapter 9.
   - ☑ Yes: Document results in Section II and proceed to step 6.
   - ☐ No: Do not accept for use and contact seller for corrective action.
6. Does the unit seem to be operating properly? Refer to manufacturer specifications.
   - ☑ Yes: Proceed to step 7.
   - ☐ No: Do not accept for use and contact seller for corrective action.
7. Have all accessories been included in shipment?
   - ☐ Yes: Proceed to step 8.
   - ☐ No: Do not accept for use and contact seller for corrective action.
8. If ownership is loan, demo, rental, or other, how long will the device be in the hospital? If hospital owned or leased, proceed to step 9.
   - ☐ Less than 6 months: Write the serial number in the equipment ID field in Section I and proceed to step 15.
   - ☑ 6 months or greater: Proceed to step 9.
9. Have (2) two operator, (2) two service manuals, **OPERATING & DIAGNOSTIC SOFTWARE** been included in shipment?
   - ☐ Yes: Proceed to step 10.-- **SOFTWARE COPIES SHOULD BE RETAINED IN CLINICAL TECHNOLOGY SERVICES.**
   - ☑ No: This is basis for non-acceptance. Evaluate literature needs. If adequate proceed to step 10. Otherwise do not accept for use and contact seller for corrective action.
10. Has technical service training and operator training been provided for the device?
    - ☐ Yes: Proceed to step 11.
    - ☑ No: This is basis for non-acceptance. Evaluate educational needs. If training is adequate proceed to step 11. Otherwise do not accept for use and contact seller for corrective action.
11. Will the device be included in the ACTS Planned Maintenance Program? Refer to Table I for inclusion criteria. (Note: All equipment items that are the responsibility of ACTS will be inventoried. The risk assessment determines inclusion in the PM program only.)
    - ☑ Yes: Proceed to step 14.
    - ☐ No: Proceed to step 15.
12. Assign a planned maintenance standard and inspection frequency to the device. Complete the remaining applicable fields in Section I and proceed to step 15.
13. Complete Section II; inventory the device and sign below.

Approved by: Daniel Miller Date: 3/1/2005

007517

ASSET INVENTORY DETAIL

BAY HEALTH

ARAMARK

00016301

Identification

Asset Number:	848021
Serial Number:	US0010381
System:	DEFIBRILLATORS
Object:	M4735A
Common Name:	Bi-Phasic Defibrillator
Service:	CEM
Class:	DEFIB./MON., BATT. PWRD.-11-129A
Manufacturer:	AGILENT TECHNOLOGIES (PHILIPS MEDICAL SYSTEMS)

Location

Zone:	KGH
Building:	Kent General Hospital
Floor:	3 rd
Area:	3 West
Room:	

PM

Base Month:	2/2005
Shutdown Months:	000000000000
Priority:	Urgent
Printer:	
Link Group:	
Shop:	

PM Indicators

Indicator - 1	
Indicator - 2	
Indicator - 3	
Frequency:	
Frequency:	
Frequency:	

Miscellaneous

Inventory Date:	
Installation:	
Storage Date:	

Warranty

Disposal Date:	
Labor Start:	10/15/2001
Labor End:	10/15/2006
Material Start:	10/15/2001
Material End:	10/15/2006

Risk Factor

Equip Type:	Medical	
Function:	8	Life Support
Risk:	7	Death or Serious Injury
History:	1	0 - 1
Total Risk:	17	
Tier:	Tier 1 (High Risk)	
PM Schedule:	Regular	

Financial

Purchase Price:	
CMI Allocation Cost:	
Cost Center:	11-6120 - 3W MED/SURG

Personnel

Employee:	
Contact 1:	
Contact 2:	

Note:

User Defined

18177

ASSET INVENTORY DETAIL

BAY HEALTH

ARAMARK

00016301

Identification

Asset Number:	848232	Common Name:	Pulse ox, Finger unit
Serial Number:	040802702	Service:	CEM
System:	PHYSIOLOGIC MONITORING SYSTEMS	Class:	OXIMETER, PULSE-17-148A
Object:	3420Y	Manufacturer:	BCI INTERNATIONAL

Location

Zone:	KGH
Building:	Kent General Hospital
Floor:	1 st
Area:	Rapid Admission
Room:	

PM

Base Month:	2/2005
Shutdown Months:	000000000000
Priority:	Routine
Printer:	
Link Group:	
Shop:	

PM Indicators

Indicator - 1	
Indicator - 2	
Indicator - 3	
Frequency:	
Frequency:	
Frequency:	

Miscellaneous

Inventory Date:	2/24/2005
Installation	2/24/2005
Storage Date:	

Warranty

Disposal Date:	
Labor Start:	2/24/2005
Labor End:	2/24/2006
Material Start:	2/24/2005
Material End:	2/24/2006

Risk Factor

Equip Type:	Medical	
Function:	5	Essential - Diagnostic
Risk:	5	Inappropriate Therapy, Misdiagn
History:	1	0 - 1
Total Risk:	11	
Tier:	Tier 2 (Medium Risk)	
PM Schedule:	Regular	

Financial

Purchase Price:	
CMI Allocation Cost:	$320.00
Cost Center:	11-6160 - RAPID ADMISSIONS UNIT

Personnel

Employee:	
Contact 1:	
Contact 2:	

Note:

User Defined

85740

Exhibit C

Memorandum

Date: 3/16/2005

To: Memorandum for File

Cc: Tom Cuthbertson, District Manager; Thomas Lodge, Director, HR

From: Jonathan Hill, Director, Clinical Engineering

RE: Dan Miller and Documentation Issues

This is a memorandum for record describing the Verbal Counseling given to Dan Miller on this date.

Background – When Dan Miller returned from Short Term Disability in early December he was given copies of all Team Meeting Minutes during his absence (September 2004 – December 2004). I asked him to read through them and if there were any questions he needed to bring them to my attention. I checked back with Dan each week in December to assess whether he had read the minutes and had any questions. Each time Dan mentioned he was reading them and did not have any questions.

The counseling started with my asking the question if he read through the team meeting minutes. He stated that he had. In October's minutes a directive was given that any work order without an asset needs to be brought to my attention for discussion and approval. I asked him about work orders 5088, 4873 and 4871. Dan explained he had a computer access problem. I talked with him and he stated that sometimes the computer would not let him access ISIS. I explained that this issue is unrelated and it should have been brought to my attention sooner. Aramark computer problems and payroll problems are to be addressed by me and not on a work order. I further explained that even though he was on the phone for these issues, he could have been productive by working on equipment. I talked to him about the 5.5 hours he took for Mandatory Testing. This is excessive and again should not be addressed on a work order.

In November's minutes a directive was given that each technician needs to identify proper work order type and pertinent information needs to be entered on a work order. Use of "Other" as a work order type is to be limited. On the same three work orders mentioned above the work order type should not have been other but Administrative – undefined. Two of the work orders (4873, 4871) were missing the cost center, employee and location with 4873 missing the priority entry. Dan explained that he needed to account for his time. I continued to say that was true with only 90% of his time needing to be on work orders. That left 45 minutes during each day he could have used to accomplish these tasks without having to put that time on a work order. I discussed that the issue here was that the wrong type of work order was selected and that all applicable entries needed to be in each work order.

In December's minutes was a discussion of Rounds work orders and explained that rounds needed to be conducted daily (Maximum time peer day one hour) with one work order for each month. In work order 5895, Dan took up to 2.5 hours to do rounds. During this entry and another totaling 1.5 hours, he stated that he entered work orders into the system for equipment that was dropped off at the shop. I explained that this time should have been split amongst the work orders opened and not a collective time entry on a rounds work order. Dan agreed.

The discussion turned to assigning proper assets to work orders. There was a video tower that was reported by the Operating Room as not taking pictures. Dan responded to the call. Instead of addressing the issue in the OR, Dan brought the video tower to the shop. The tower sat in the shop for over an hour before I

EXHIBIT
Hill 6
case 2/14/07

Miller 8

addressed the issue. After verifying the symptom, I determined that the source cable for picture taking was disconnected from the camera controller. The repair took 5 minutes and I delivered the tower back to the OR. I asked Dan if he opened a work order and he did not. I told him not to worry about it that I would open the work order (5943). I found out two weeks later (Feb. 28th) that Dan did open a work order (5956) and he assigned asset number 292997 which was the video monitor and not the actual device that had failed. I explained that Dan should not have taken 30 minutes on the work order (work performed did not match time taken) nor assigned that asset number to the work order as it was not the device that had the problem. Dan Agreed.

I did have these discussions with Dan to address these issues.

Jonathan Hill, Director, Clinical Engineering

Exhibit D

ARAMARK

Hourly Performance Plan Form

☐Coaching Discussion **XCounseling Discussion** ☐Formal Warning

☐Follow-up Discussion ☐Suspension Notice (Fact finding Only, Do not complete the 2nd and 3rd boxes)

Name: Dan Miller Social Security #: 183-42-5008

Position: CE Technician Comp. Name: Bayhealth Medical Center # 7517

Your Conduct / performance requires improvement for the following reasons: (Describe the performance issue and reasons improvement is required, use additional paper if necessary)

- Failure to remain with and follow-up on vendor's work during install of new stress machine.
- Leaving work-site without reporting to Director on status of install.
- Failure to identify safety deficiencies during install and taking immediate action.
- Failure to keep customer updated on status of install.
- Reference: Work Orders 5958, 6052, 6061 & 6062

The expected level of performance / conduct is:

Quality Control – The technician inspects all vendor completed maintenance to ensure work requested was accomplished
Customer Relations - The technician develops a personal, sincere interest in the clinical equipment users' equipment problems.
Customer Relations - The technician responds to critical service problems immediately and personally follows through until the problem is resolved. He provides feedback to the individual concerned and changes problems into opportunities.
Vendor Relations - The technician monitors the performance of the vendors assigned and reports the findings to the manager.
Technical Knowledge - The technician recognizes, can identify, and set immediate objectives to correct maintenance and safety deficiencies.

The following solution(s) have been agreed upon to correct the conduct / performance:

When an installation occurs whether with an outside vendor or not, the install must reach a logical stopping point. If other work is interfering with the active participation of an assignment, you need to coordinate appropriately for coverage. If problems arise, you need to notify me immediately so a resolution can be achieved. When an install of a device has a safety feature not being installed properly, you need to correct this deficiency immediately. You should never leave a customer with a vendor without the customer's expressed knowledge of your leaving and estimated time of return. Finally, you should open proper work orders for the actions taken (i.e. not an inspection and anew equipment work order for the same job. This is not a first occurrence.

Date Solution(s) will be implemented: March 24, 2005 Completed: _____

Potential consequence in continuing current behavior is: Further Disciplinary Action up to and including Termination

A follow-up to discuss your progress will be held on: April 25, 2005

Employee Refused To Sign
Employee's Signature Date

Manager's Signature 3/24/05
Date

Human Resources / Other (if applicable) Date

Shawn Molloy 3/24/05 witness

Note: Employee's signature on this form indicates that this situation has been discussed. It doesn't necessarily mean the employee agrees.

Miller 9

EXHIBIT
Hill 7
2/14/07

A00049

Exhibit E

ARAMARK

Hourly Performance Plan Form

EXHIBIT
Hill 8
case 2/14/07

XCoaching Discussion ☐Counseling Discussion ☐Formal Warning

☐Follow-up Discussion ☐Suspension Notice (Fact finding Only, Do not complete the 2nd and 3rd boxes)

Name: Dan Miller Social Security #: 183-42-5008

Position: CE Technician Comp. Name: Bayhealth Medical Center # 7517

Your Conduct / performance requires improvement for the following reasons: (Describe the performance issue and reasons improvement is required, use additional paper if necessary)

During a PM inspection of a Defibrillator w/Pacing (Life Support) device you discovered that no audio tones, AED instructions and Alarms not working. This unit should have been pulled from the floor immediately upon notification to the Charge Nurse. The acquisition of a replacement item is the responsibility of the department. Users who refuse to release equipment when safety issues are involved should be reported to Risk Management and the Director of Clinical Engineering immediately.

The expected level of performance / conduct is:

Quality Control - The technician performs assigned clinical equipment electrical safety inspections. Any deficiencies are given immediate attention.

Technical Knowledge - The technician recognizes, can identify, and set immediate objectives to correct maintenance and safety deficiencies.

The following solution(s) have been agreed upon to correct the conduct / performance:

You need to realize the severity of this issue. The device was discovered with the top and bottom case having a gap which indicated some abuse issue had occurred. You need to understand that Bayhealth has policies in regards to safety issues and your responsibilities under those policies. In addition you need to conform to the Standards of Performance as listed above.

Date Solution(s) will be implemented: 4/5/2005 Completed: 4/5/2005

Potential consequence in continuing current behavior is: Further Disciplinary Action

A follow-up to discuss your progress will be held on: N/A

Employee Refuses To Sign
Employee's Signature Date

Manager's Signature 4/5/2005
Date

Human Resources / Other (if applicable) Date

Sharon Money 4/5/05 witness

Note: Employee's signature on this form indicates that this situation has been discussed. It doesn't necessarily mean the employee agrees.

Miller 10

A00041

Exhibit F

Memorandum

Date: 4/15/2005

To: Tom Cuthbertson, District Manager

Cc: Tom Lodge, HR Director

From: Jonathan W. Hill, Director of Clinical Engineering

RE: Termination Discussion with Dan Miller

I started the discussion by going over the Incomplete Work Request by Technician Assigned report dated 4/11/2005. We discussed how a work order should be statused (On Hold vs. Service), the estimated time of repair, the updating of the user with any delays in the repair process and that parts need to be put on work orders in the materials section.

The discussion turned to six preventive maintenance work orders that had various problems as well (6964, 7045, 7099, 7103, 7106 & 7124). They all related to Defibrillators (Tier 1 devices with 3 of them having pacing capabilities). Two had problems in which the parts that were installed were not applied to the work order. Three of the work orders had no output values listed for the PM checks and four did not have any alarm checks. I explained that this is unacceptable work and actions like this cannot be tolerated.

I then presented the letter to Dan. He stated that he was shocked by this and found the process unfair. Dan further stated that he had not been informed about problems with his statuses or about the need to put parts on the work orders. I explained that these are items that someone with his years of experience should have no problem with. I further explained that we have had conversations in which I pointed out discrepancies and asked him if he understood what I was asking. I reminded him that he acknowledged the problems in the past and would correct them.

I then asked for his badge, pager, keys and pocket pc. His badge was turned into security along with a bottle of percocet found in the bottom of his toolbox.

Jonathan W. Hill

FLM, Aramark CTS

Created on 4/15/2005 3:44 PM

Miller 11

A00046

Exhibit G

Request: 7105 **Preventive - Asset**

Orig. Date: 4/4/2005 WR Status: In Progress (4/4/2005 11:34:59 AM)

Shop: CTS BIOMEDICAL
Employee:
Cost Center: 11-6245 - KGH Emergency Department
Location: Kent General Hospital Floor: Room:
Problem:

Priority: Life Support
Due Date: 4/30/2005
Contact: Debbie Eberly
Reference:
Tier: 1

Description

System-Generated Preventive Maintenance

System: DEFIBRILLATORS
Class: DEFIB./MON., BATT. PWRD.-11-129A
Object: M4735A
Manufacturer: AGILENT TECHNOLOGIES (PHILIPS MEDICAL SYSTEMS)

Asset ID: 469907
Common Name: DEFIBRILLATOR/MONITOR WITH PACING
Cost Center: KGH Emergency Department
Building: Kent General Hospital
Floor:
Area: ER
Room: None
Risk Factors: Death or Serious Injury (7) /Critical - Therapeutic (8) /0 - 1 (1) Total = 16

Serial Number: US00103180
Warranty End: 10/15/2006
Indicators Previous Current

Status History

Status	Date	Employee	Shift	Repair	Regular Time	Travel Time	Over Time
In Progress	4/4/2005				1 Hrs 30 Min	0 Hrs 0 Min	0 Hrs 0 Min

Repair Description: During PM found audio tones, AED instructions, and alarms tones not working. Searched several units for simuliar Unit - has a pacer feature that is needed and Gretchen refuses to give defib up, turned situation over to J. Ritterhoff since I had to leave for day shortly. Contacted Philips ordered replacement overnite.

Totals: 1 Hrs 30 Min 0 Hrs 0 Min 0 Hrs 0 Min

Procedures

☐ REMOVE INSTRUMENT FROM AC POWER SOURCE. ALL TESTS ARE TO BE PERFORMED ON BATTERY POWER. Every 6 months

CLEAN AND INSPECT ALL EXTERNAL SURFACES, HARDWARE AND CONNECTORS FOR DAMAGE.

CLEAN AND INSPECT EXTERNAL COMPONENTS: THE LENGTH OF PADDLE CABLE ASSY, POWER CORD, AND PATIENT CABLES.

PERFORMANCE DATA
INDICATED VS. ACTUAL
_____ - _____
_____ - _____
_____ - _____
_____ - _____
_____ - _____
_____ - _____

CHECK ALL SWITCHES, KNOBS, CONTROLS AND INDICATORS FOR PROPER RANGE AND MECHANICAL OPERATION.

INSPECT POWER CORD, STRAIN RELIEF AND PLUG FOR DAMAGE OR DETERIORATION.

VERIFY CORRECT FUSE SIZE.

INSPECT PADDLES FOR PITS, POLISH WITH EMERY CLOTH IF PITS ARE PRESENT.

CLEAN AND INSPECT PADDLE ASSEMBLY FOR WEAR, DETERIORATION CRACKS, SPLITS AND PHYSICAL DAMAGE.

INSPECT APEX PADDLE FOR PUSH TO CHARGE BUTTON AND CHARGE INDICATOR OPERATION. USE TO STORE 200 JOULES. DISCHARGE THE 200 JOULES INTO INTERNAL TEST LOAD NOTING ILLUMINATION OF TEST LOAD DISPLAY.

WITH AN OHMMETER, CHECK CONTINUITY BETWEEN EACH PADDLE AND ASSOCIATED CONNECTOR.

SELECT AND STORE FIVE (5) ENERGY LEVELS: 50,100,200,300 & MAX. RESPECTIVELY. DISCHARGE AND RECORD STORED ENERGY INTO AN DEFIB ANALYZER AND VERIFY FOR PLUS OR MINUS 25 PER CENT TOLERANCES

POWER UNIT AND CHECK ALL LAMPS AND PILOT LIGHTS.

AFTER 9TH DISCHARGE, RECORD CHARGING TIME FOR MAX SETTING AND VERIFY AT 10 PLUS OR MINUS 2 SECONDS. IF NOT, REPLACE BATTERIES.

CHECK AND RECORD CHARGING TIME TO MAXIMUM ENERGY IN SECONDS.

CHECK FOR PROPER INTERNAL DISCHARGE OF STORED ENERGY.

VERIFY SYNC OPERATION. ATTEMPT DISCHARGE ON AND OFF 'R' WAVE NOTE BRIGHT SPOT MARKER ON CRT TRACE.

NOTE: ALL CALIBRATIONS ADJUSTMENTS ARE EXPLAINED IN SERVICE MANUALS.

MEASURE VARIOUS OUPUT ENERGIES, RECORD ON APPROPRIATE LABEL AND ATTACH LABEL IN CONSPICUOUS LOCATION.

MEASURE AND RECORD OUTPUT ENERGY AFTER REMAINING AT MAXIMUM WATTS SECOND FOR ONE MINUTE.

MEASURE AND RECORD ENERGY OUTPUT OF TENTH REPEATED DISCHARGE AT MAXIUMUM SETTING.

☐ TEST SYNCHRONOUS FUNCTION WITH A HEART SIMULATOR AND CONNECTED TO A MONITOR.
☐ TEST ALL AVAILABLE POWER SUPPLY VOLTAGES. NOTE -USE EXTREME CAUTION WHILE MEASURING HIGH VOLTAGE CHARGING POWER SUPPLY. Annually

☐ PERFORM ANNUAL CALIBRATION IN ACCORDANCE WITH MANUFACTURER'S INSTRUCTIONS.
DISASSEMBLE AND REMOVE ALL DUST AND FOREIGN MATERIALS. Every 6 months

DISASSEMBLE, REMOVE DUST WITH DRY AIR AND BRUSH. CLEAN ALL PRINTED CIRCUIT BOARDS, CONNECTORS AND RECEPTACLES.

VISUALLY INSPECT ALL INTERNAL PARTS FOR SIGNS OF WEAR, DETERIORATION, CORROSION, BREAKAGE, ABUSE OR OVERHEATING.

VERIFY PROPER OUTPUT WAVEFORM USING AN OSCILLOSCOPE. A PERMANENT RECORD MAY BE OBTAINED USING A POLAROID CAMERA OR STRIP CHART RECORDER.

New Materials: Qty Cost Total Cost

Misc.

Completed By: _____
Response Date: ___/___/___
Response Time: ___:___
Duration: _____

Sign Off By: _____
Completed Date: ___/___/___
Completed Time: ___:___
Rpr Code: _____

Exhibit H

correct this deficiency immediately.

So in other words, you are instructing Mr. Miller that he needs to correct the safety deficiency. But is it your testimony that he actually created the safety deficiency himself by installing the device?

A. **He told me so.**

Q. Is there a reason you did not indicate that in this form?

MR. DELANY: Objection to the form of the question.

BY MR. PRIMOS:

Q. Let me just --

A. **Well, that is my writing style.**

Q. Well, let me ask you this question, Mr. Hill. Is there any indication in this form that Mr. Miller is the one who installed the switch improperly?

A. **The only thing I have in here is that he needs to ensure that it is installed correctly --**

Q. Okay.

A. **-- which is meant by the wording in that statement.**

Q. And where is that indicated?

A. **The wording of the statement, when an install of a device has a safety feature not being installed properly, you need to correct this deficiency immediately. It is his responsibility to do that. It is his responsibility to ensure that the entire device is safe and fully functional prior to leaving the work site. It is his responsibility to communicate with the appropriate people during the install that everything was done accurately and correctly, and he failed to do that.**

It took me three additional days' work to go ahead and do what he was supposed to do because he did not do it appropriately the first time.

Q. Now, if you could refer to Hill 8, which is the next disciplinary incident, this refers to a disciplinary incident that you addressed on April 5, 2005, correct?

A. **Yes.**

Q. And that is your signature toward the bottom, correct?

A. **Yes.**

Q. And Mr. Miller refused to sign the form, correct?

A. **Yes.**

Q. Now, I noticed that in both Hill 8 and Hill 7, Sharon Money signed the form, as well. Is there a reason she signed those forms?

A. **She was outside my door when they were given.**

Q. But is there a reason why she signed the form as a witness?

A. **Just a secondary person who was there who had heard the conversation and could testify to the fact that he refused to sign.**

Q. But in other words --

(Following a discussion off the record:)

BY MR. PRIMOS:

Q. If you refer to Hill 4, neither Ms. Money nor any other person signed that form as a witness, correct?

A. **Because Dan Miller signed it.**

Q. So in other words, the reason for her signing it was because Dan Miller refused to sign it?

A. **Exactly. At least there was somebody there that could testify to the fact that that conversation took place.**

Q. I understand. Now, this incident hard to do with a defibrillator, correct?

A. **Correct.**

Q. And your complaint with Mr. Miller with regard to this incident was that the unit should have been pulled from the floor, and it was not, correct?

A. **No.**

Q. That was not your complaint with Mr. Miller?

A. **My complaint with Mr. Miller was, number one, he did not pull it from the floor. Number two, if he was not going to pull it from the floor, he was supposed to tag it as defective. He knew at that point in time that defibrillator was not fully operational. And he left it on the floor for an hour and a half without actually indicating to anybody else that it was defective by putting that lockout tag-out sign on it.**

Q. But there is no indication --

MR. DELANY: Are you done with your answer?

THE WITNESS: Yes.

BY MR. PRIMOS:

Q. But there is no indication on this form with regard to tagging the item, correct?

A. **That was put into the substance of the conversation, which under the following solutions have been agreed upon, was that he needs to understand that BayHealth has policies with regard to safety issues and**

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he has responsibilities under those policies.
He should have pull the defib from the floor, yes. But if he wasn't pulling it from the floor, he should have tagged it.
Q. But you would agree that the tagging issue is not identified in this form, correct?
A. **It is referred to down below.**
Q. And where is it referred to?
A. **In the statement which I just read, which is you need to understand that BayHealth has policies with regard to safety issues and your responsibilities under these policies.**
(Hill Exhibit Number 11 was marked for identification and attached to the record.)
BY MR. PRIMOS:
Q. Mr. Hill, this is an excerpt from the Aramark Policy Manual, correct, that has been marked as Hill Number 11?
A. **Yes.**
Q. Does this policy apply to the incident in question?
A. **It should.**
Q. What do you mean it should?
A. **Yes. There are definite aspects in this**

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policy that does apply to this.
Q. And what aspects in particular apply to this incident?
A. **Understand the protocol, number four, defective equipment that exhibits deficiencies that preclude safe or defective use shall be identified as such and removed from service.**
Q. And then it goes on to state that: If for any reason the equipment cannot be removed from service, there are certain steps to be taken? Correct?
A. **Absolutely. And the first one is A, which is affix a placard to the unit to warn potential users that the equipment is defective and must be used with caution. The placard must also be dated and include an ACTS department contact name and phone number.**
That is what is known as a defective tag, and that placard was not placed on the device. The device was left there for normal use.
Q. Right. Is it your understanding that in reference to this particular incident, the equipment in question could not be removed?
A. **It should have been removed.**
Q. Well, what we just read about the placard applies in a circumstance where the equipment could not

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be removed, correct?
A. **According to Dan Miller, he says the equipment could not be removed. I disagree with that assessment.**
Q. And why do you disagree with that assessment?
A. **I disagree with that assessment because I went talked to the charge nurse, which is what you are suppose to do to notify them that there is defective equipment in your area, and she let me take it.**
Q. What was the name of that charge nurse?
A. **The first name Gretchen, and the last name I do not know.**
Q. Is it Gretchen Larrimore?
A. **It could be, yes.**
Q. Did Mr. Miller tell you that she had told him that the equipment could not be taken from the floor?
A. **Dan Miller, during my subsequent investigation later, told me that she said that. But I was not able to confirm that with her.**
Q. Why did you go to the floor and remove the equipment?
A. **Because I was down there in the shop**

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discussing an issue with John Ritterhoff when Dan came in. Dan said there is a defibrillator up in the intermediate care unit that has no sounds on it, and he's got to go. And he grabbed his coat and left.
I immediately went up to the floor, because you can't leave a defibrillator like that on the floor. There was no defective tag on it. I found the case had been separated in the back by approximately one quarter of an inch across the back side, which left an even increased hazard up there in the work area.
So I went and I talked with Gretchen. I showed her the device. I pulled it from the floor. I affected repair on it and got it back up there within an hour. And then I proceeded to investigate the entire incident.
Q. So in other words, Mr. Miller did make you aware of the situation, correct, before he left?
A. **Correct.**
Q. So the situation was handled appropriately ultimately after he informed you of the situation, correct?
A. **But it should have been handled appropriately long before that.**
Q. What do you mean long before?

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A. From the minute he -- The first step in any preventative maintenance procedure is to look at the physical condition of a device. When I investigated with Dan Miller about the defibrillator, he said he did not notice that gap in the case. A gap in the case can allow fluids to infiltrate into the device, creating an electrical shock hazard for both the patient and the user.

And then he told me when he was looking for a replacement form, which was not necessary, for it is the intermediate care unit in which on one end of the floor were two crash carts that were available for use and the ICU on the other side, which had three crash carts. All he had to do was tell Gretchen that she could use either one of those and communicate to her nurses so they had appropriate coverage in the area and then remove the defibrillator immediately.

He chose to walk around and look for another defibrillator and left that defibrillator there with no note, no nothing on it. And that created a safety issue for the facility, patients, staff. It was inappropriately handled from the get go. It sat there for an hour and a half being inappropriately handled, and it should have been addressed immediately.

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Q. So the period of time that transpired between Mr. When Mr. Miller initially discovered the problem and when he informed you was an hour and a half; is that correct?

A. Yes, according to his own testimony.

(Hill Exhibit Number 12 was marked for identification and attached to the record.)

BY MR. PRIMOS:

Q. Mr. Hill, looking at what has been marked as Hill Exhibit Number 12, this is a response written by Mr. Miller regarding the defibrillator incident. Your attorney is already in position of this.

I would like you to look at the second sentence of this document. It says: With 23 years of in-hospital biomedical equipment servicing, I was always instructed never remove an operation critical life support item from a crash cart without a working replacement.

Whether or not Mr. Miller was instructed of that, as you obviously wouldn't know about all of his experience, but is that an appropriate statement, that --

A. No.

Q. -- an operation critical life support item

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from a crash cart without a working replacement?

A. There is insufficient information there to go with. That is too broad and vague of a statement to rely on.

Q. What is the insufficient information?

A. The insufficient information relies on what exactly you are trying to accomplish with that particular device. Okay. It's a defibrillator, for instance, on a crash cart. Okay. If you are up there doing a preventative maintenance on a defibrillator and you need to remove it from the crash cart and you know you are going to have it for a finite period of time and the nurses are made aware and they are able to go ahead and ensure that there was appropriate coverage for the area, then yes, it can be removed.

But it all goes back to the communication issue. If you went up there and just took the defibrillator and walked off and didn't tell anybody, this would be an accurate statement. But as long as you adequately communicate with the other caregivers in the medical facility, there is no reason why that piece of equipment couldn't be pulled for regular preventative maintenance.

If it's a corrective, if it was broken and

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had to be repaired, of course, it had to be removed. But again, there is appropriate coverage for those areas. You have to communicate. You have to ensure that it's there.

Q. Now, if you could look at the third paragraph of Hill 12, the third sentence, Mr. Miller, states -- and this is the following day, after the incident occurred; in other words, the following day after you removed the defibrillator from the floor.

It says: Later the morning -- I think it should be that morning -- later that morning Mr. Hill could be heard screaming to someone on the phone with his door closed -- he know the level of safety called/required in any incident, and this was not the way he was trained and so on to defend a point.

Is it true that you were screaming to someone on the phone, something along these lines about he knows the level of safety required?

A. No. As a matter of fact, I find a lot of this statement totally erroneous.

Q. Is it true that you had a conversation with someone over the phone where you indicated that something along the lines of he knew the level of safety required?

A. No. I've never utilized those words in that sequence before.

Q. Did you have any conversation with anyone the following day -- in other words, the day after you removed the defibrillator -- did you have any telephone conversation with anyone about the incident?

A. No telephone conversation on the day after with anyone regarding the incident; I did have a face-to-face conversation with Daniel Miller.

Q. Now, if you go on there in the third paragraph, it says: Later at lunch, John Ritterhoff from remarked that everyone heard his conversation.

In other words, your conversation. He remarked -- in other words, you remarked -- he was speaking to his superior, Tom Cuthbertson (area manager).

MR. DELANY: Objection to the form of the question. I don't agree with your interpretation that he remarked refers to Jonathan Hill.

MR. PRIMOS: Okay. Well, I agree. It could refer to John.

MR. DELANY: It could refer to Ritterhoff.

MR. PRIMOS: Yes, right. It could refer to John Ritterhoff. I'm sorry. That is what I meant.

BY MR. PRIMOS:

Q. Do you recall this conversation occurring at lunch?

MR. DELANY: What conversation --

BY MR. PRIMOS:

Q. In other words, the conversation where John Ritterhoff was saying everyone heard your conversation on the phone?

A. No. I mean I have lunch with the guys most every day.

Q. And you don't recall this conversation?

A. No.

Q. Did you have a discussion with John Cuthbertson on the phone about this defibrillator incident?

MR. DELANY: At any time?

BY MR. PRIMOS:

Q. At any time.

A. Yes, I could have, yes. I would say yes.

Q. Did you have a discussion with Tom Cuthbertson on the phone about this defibrillator incident the day after the defibrillator was removed?

A. I answered that; no.

Q. You didn't. Do you recall when your

conversation with Mr. Cuthbertson occurred?

A. No.

Q. Was it within a week of the incident?

A. Most likely, yes.

Q. And what occurred during that conversation?

A. I discussed with Tom Cuthbertson regularly any disciplinary that I give to the technicians to make sure that he is fully aware of what happened and what disciplinary I'm going to write up for him.

Q. In this discussion with Mr. Cuthbertson, did he try to talk you out of giving Mr. Miller a write-up?

A. No.

Q. In that discussion with Mr. Cuthbertson, did you say anything similar to what is indicated here? He knows the level of safety required. This was not the way he was trained. Did you say anything similar to that in your discussion with Mr. Cuthbertson?

A. No, no.

Q. Now, looking at the last paragraph on Hill 12, it says: I was subsequently called into his office why I did not perform as he believed he would in the same situation. Then it says: Given my disciplinary action to sign, which I refused. And then it says: He then began to speak hypothetically -- if he had a job

where he was experiencing anxiety for harassment and unfair treatment, he would not let it jeopardize his health. He would resign and find another job elsewhere. He would live off family, even risk being -- I think that should be destitute -- but not work under those conditions.

Did you have a conversation along those lines with Mr. Miller?

A. No.

Q. Was anyone else present during your conversation with Mr. Miller about the incident?

A. Sharon Money was right outside my door, and my door was open.

Q. But did she hear the entire conversation?

A. Yes. Her desk sits right outside my door.

Q. Did anyone else witness the conversation, other than Ms. Money?

A. To my knowledge, no.

MR. PRIMOS: I think this may be a good stopping point.

(Following a luncheon recess:)

BY MR. PRIMOS:

Q. I guess the next thing I would like you to refer to, Mr. Hill, is Hill 9. Now, first of all, is

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that your signature toward the bottom of the page? I'm sorry. I'll let you look. Is that your signature toward the bottom of the page, Mr. Hill?

A. Yes, it is.

Q. And this appears to be a memo that was sent by you to Tom Cuthbertson, correct?

A. Yes.

Q. And you were memorializing your termination discussion with Mr. Miller, correct?

A. Yes.

Q. Now, prior to your having this meeting with Mr. Miller -- Well, I'm sorry. Strike that. The memo is dated 4/15/2005. Is that the same date that your termination discussion with Mr. Miller was held?

A. Yes.

Q. And prior to your having this termination discussion with Mr. Miller, had you previously had discussions with Mr. Cuthbertson about terminating Mr. Miller?

A. I had talked to Mr. Cuthbertson and Tom Lodge two days prior to this.

Q. So that would have been the 13th of April?

A. Yes.

Q. And can you tell me what occurred during

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that discussion?

A. I had called -- I had sent them both an e-mail in reference to requesting a teleconference. And I had discussed with them about the two safety incidences with Dan Miller and subsequently, following that, some discrepancies I had found with other defibrillators on the floor. And these work orders referenced those defibrillator preventative maintenance work orders.

And I told them that when -- with the two safety violations and all of these discrepancies, he did not -- he was not safe enough to have working for us any longer.

Q. And what was their response?

A. Well, they had asked to -- they had already known about the two previous safety violations. And we discussed those six particular work orders. And at the end of the conversation, they agreed that, you know, termination had to be done. So Tom Lodge drafted a letter for Tom Cuthbertson. And on that day, I presented it to him.

Q. Now, what we are looking at here, Hill Exhibit Number 9, that was not the letter that was drafted, correct?

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A. No.

Q. And it is not the letter that you presented to Mr. Miller?

A. That's correct.

Q. These six work orders that are referenced in Hill 9 by number, are they still in existence?

A. Yes.

Q. Are they in electronic format?

A. Yes. I am required to maintain a record of all devices, from cradle to grave; in other words, once they come into the facility until they leave and then the subsequent years after that. So yes, all of these do exist on our computer system.

Q. When you say the subsequent years after that, you are required to maintain these records for a period of time, even after the equipment has left --

A. Absolutely.

Q. -- the facility?

A. Absolutely, absolutely.

Q. Is it a set period of time?

A. It is depending on whether or not the particular device has patient sensitive information contained in it. For those items, I am required to keep those records for six years.

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Q. Would these work orders have patients' sensitive information in them?

A. No, they are not. They are defibrillators. They don't record any patient information within them.

Q. So how do you know that all of these work orders are still in existence? Isn't it possible that some of these defibrillators may no longer be in the facility?

A. Even if they weren't in the facility, the time frame -- For instance, this is April 2005. It's less than two years. I usually keep records for five.

MR. PRIMOS: Okay. I may be requesting those, as well.

BY MR. PRIMOS:

Q. Now, in the third paragraph of Hill 9, where you say, I then presented the letter to Dan, that refers to the letter that I believe you said Mr. Lodge had drafted?

A. Yes. It's a letter of termination.

(Hill Exhibit Number 13 was marked for identification and attached to the record.)

BY MR. PRIMOS:

Q. Mr. Hill, I have just handed you what has been marked as Hill Exhibit Number 13. Is this the

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the importance of getting this accomplished correctly.

Q. And when would you say that Mr. Ritterhoff was at a point where this was no longer a problem for him individually?

A. **Well, what had happened was is in August, when we got the ISIS Pro system in there, I was already highly familiar with the program. So I sat Mr. Ritterhoff and I sat Sterling Townsend and I sat Greg Wilson down in front of the computer system. And I demonstrated for them that the items I could find with no problem at all that were totally screwed up. They had no idea it was that bad. They had no idea how horrible it was. And they were like: Oh, my goodness, I can't believe this has been going on. That was the statement that was given to me.**

It was from that time on that they truly realized this was important stuff and it has to get accomplished.

Q. But my question is: At what point was it no longer a problem for Mr. Ritterhoff, as far as identifying equipment and placing it into the system?

A. **As far as a specific date, I have no idea. I just know that when we brought in ISIS Pro and very shortly after my meeting with those individual, who were**

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the senior technicians in the shop or the ones that had the most time behind them, that we actually took a look at this. And it was very shortly after that I noticed there were no problems with those particular gentlemen or any others.

Q. So you would say the fall of '04?

A. **That would be a fair assessment.**

Q. Okay. Who is Neil Newlin? Does that name ring a bell.

A. **Yes.**

Q. Who is that?

A. **He's a general repair technician.**

Q. Who does he work for?

A. **He works for Aramark.**

Q. In the Kent location?

A. **Yes.**

Q. And how long has he been in employed there?

A. **He's been there since November.**

Q. Since November?

A. **Yes.**

Q. Of '06?

A. **Yes.**

Q. Were you the one that made the decision to hire him?

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A. **It was a group decision. He does not work as a biomed technician. He works as a general repair technician.**

Q. What does mean?

A. **He takes care of the smaller items that are repetitive.**

Q. Do you know what his age is?

A. **He's in his 40s.**

Q. In his 40s?

A. **Yes.**

MR. PRIMOS: I have no further questions.

BY MR. DELANY:

Q. On the issue of defibrillator, do you recall your testimony in that area?

A. **Yes.**

Q. Okay. You had testified that Mr. Miller failed to -- I believe you used the words tag out the machine when he left it on the floor?

A. **Correct.**

Q. Did it matter to you whether it was an hour and a half or some other period of time that he left that machine on the floor untagged?

A. **He never should have left the machine without putting a tag on the device.**

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Q. So the time that he was gone and left the machine without a tag, is that relevant to you?

A. **Absolutely, that is the reason he was written up.**

Q. But the length of the time?

A. **The length of the time only adds to the gravity of the situation.**

Q. You referenced the personnel files that were there prior to your arriving at the BayHealth system. Do you remember your testimony?

A. **Yes.**

Q. You have no direct knowledge of how those files were maintained prior to your arrival, correct?

A. **No, I do not.**

Q. And whether or not things have been moved and purged from your files prior to your arrival, you have no direct knowledge of that, do you?

A. **I have no direct knowledge.**

Q. I'm just referring you to Hill 4 --

A. **Yes.**

Q. -- to the write-up of Mr. Miller on March 2nd of '05.

A. **Right. The original write-up was March 2nd, but it was actually delivered on March 4th.**